Complete Summary

GUIDELINE TITLE

Substance misuse and alcohol use disorders. In: Evidence-based geriatric nursing protocols for best practice.

BIBLIOGRAPHIC SOURCE(S)

Naegle M. Substance misuse and alcohol use disorders. In: Capezuti E, Zwicker D, Mezey M, Fulmer T, editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company; 2008. p. 649-76. [71 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Substance abuse including:

- At-risk drinking
- Smoking cigarettes or using smokeless tobacco
- Smoking marijuana
- Prescription or illicit drug misuse
- Heroin or opioid dependence

GUIDELINE CATEGORY

Counseling
Evaluation
Management
Prevention
Risk Assessment
Screening
Treatment

CLINICAL SPECIALTY

Geriatrics
Nursing
Psychology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Social Workers
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

To implement best nursing practices to care for older persons with drug, alcohol, tobacco, or other drug abuse or dependencies

TARGET POPULATION

Older persons with drug, alcohol, tobacco, or other drug abuse or dependencies

INTERVENTIONS AND PRACTICES CONSIDERED

Assessment

1. Screening for alcohol, tobacco and other drug use
    - Assessment/screening tools
2. Atypical presentation
3. Central nervous system (CNS) intoxication
4. At-risk drinking
5. Withdrawal of CNS depressant drugs
6. Sleep disturbance, anxiety, depression, problems with attention and concentration
7. Dependence on cigarettes or smokeless tobacco

Management/Treatment

1. At-risk drinking
    - Hydration
    - FRAMES intervention
2. Cigarettes or smokeless tobacco
    - Five A's intervention
3. Marijuana
    - Referrals
4. Heroin or opioid dependence
    - Methadone
    - Buprenorphine
    - Naltrexone
5. Relapse prevention

MAJOR OUTCOMES CONSIDERED

- Decreased substance consumption
- Smoking cessation
- Withdrawal
- Physical health and function
- Quality of life, sense of well-being and mental health
- Satisfaction with interpersonal relationships
- Productivity and mental alertness
- Falls and other accidents
- Relapse rate

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Although the AGREE instrument (which is described in Chapter 1 of the original guideline document) was created to critically appraise clinical practice guidelines, the process and criteria can also be applied to the development and evaluation of clinical practice protocols. Thus the AGREE instrument has been expanded for that purpose to standardize the creation and revision of the geriatric nursing practice guidelines.

The Search for Evidence Process

Locating the best evidence in the published research is dependent on framing a focused, searchable clinical question. The PICO format—an acronym for population, intervention (or occurrence or risk factor), comparison (or control), and outcome—can frame an effective literature search. The editors enlisted the assistance of the New York University Health Sciences librarian to ensure a standardized and efficient approach to collecting evidence on clinical topics. A literature search was conducted to find the best available evidence for each

clinical question addressed. The results were rated for level of evidence and sent to the respective chapter author(s) to provide possible substantiation for the nursing practice protocol being developed.

In addition to rating each literature citation to its level of evidence, each citation was given a general classification, coded as "Risks," "Assessment," "Prevention," "Management," "Evaluation/Follow-up," or "Comprehensive." The citations were organized in a searchable database for later retrieval and output to chapter authors. All authors had to review the evidence and decide on its quality and relevance for inclusion in their chapter or protocol. They had the option, of course, to reject or not use the evidence provided as a result of the search or to dispute the applied level of evidence.

Developing a Search Strategy

Development of a search strategy to capture best evidence begins with database selection and translation of search terms into the controlled vocabulary of the database, if possible. In descending order of importance, the three major databases for finding the best primary evidence for most clinical nursing questions are the Cochrane Database of Systematic Reviews, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and Medline or PubMed. In addition, the PsycINFO database was used to ensure capture of relevant evidence in the psychology and behavioral sciences literature for many of the topics. Synthesis sources such as UpToDate® and British Medical Journal (BMJ) Clinical Evidence and abstract journals such as *Evidence Based Nursing* supplemented the initial searches. Searching of other specialty databases may have to be warranted depending on the clinical question.

It bears noting that the database architecture can be exploited to limit the search to articles tagged with the publication type "meta-analysis" in Medline or "systematic review" in CINAHL. Filtering by standard age groups such as "65 and over" is another standard categorical limit for narrowing for relevance. A literature search retrieves the initial citations that begin to provide evidence. Appraisal of the initial literature retrieved may lead the searcher to other cited articles, triggering new ideas for expanding or narrowing the literature search with related descriptors or terms in the article abstract.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

Level I: Systematic reviews (integrative/meta-analyses/clinical practice guidelines based on systematic reviews)

Level II: Single experimental study (randomized controlled trials [RCTs])

Level III: Quasi-experimental studies

Level IV: Non-experimental studies

Level V: Care report/program evaluation/narrative literature reviews

Level VI: Opinions of respected authorities/Consensus panels

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Levels of evidence (I – VI) are defined at the end of the "Major Recommendations" field.

Parameters of Assessment

- Screening for alcohol, tobacco, and other drug use is recommended for all community-dwelling and hospitalized older adults. It is essential that the nurse:
    - State the purpose of questions about substances used and link them to health and safety
    - Be empathic and nonjudgmental
    - Ask the questions when the patient is alcohol- and drug-free
    - Inquire regarding patient's understanding of the question (Aalto, Pekuri, & Seppa, 2003 **[Level III]**).
- Assessment/Screening Tools
    - The Quantity-Frequency Index (Khavari & Farber, 1978 **[Level VI]**. *Review all classes of drugs*: alcohol, nicotine, illicit drugs, prescription drugs, over-the-counter (OTC) drugs and vitamin supplements, for each drug used. *Record the Types* of drugs, including types of beverages; *Frequency*: the number of occasions on which the drug is consumed (daily, weekly, monthly); *Amount of drug consumed* on each occasion during the last 30 days. The psychological function that the substance serves for the individual is also important to identify. The Quantity-Frequency Index tool should be part of the intake nursing history. The Brown Bag approach is useful (Armor, Polish, & Stambul, 1978 **[Level VI]**). The patient is asked to bring all drugs and supplements listed herein to the interview with the provider.
    - Short Michigan Alcohol Screening Test-Geriatric Version (SMAST-G):

      Highly valid and reliable, this is a 10-item tool that can be used in all settings. Three minutes for administration. This instrument is derived from the MAST-G with a sensitivity of 93.6% and positive predictive values of 87.2% (Blow et al, 1992 **[Level III]**).

    - Alcohol Use Disorders Identification Test (AUDIT):

      This 10-item questionnaire has good validity in ethnically mixed groups and scores classify alcohol use as hazardous, harmful, or dependent. Administration: 2 minutes. Sensitivity scores range from 0.74% to 0.84% and specificity around 0.90% in mixed age and ethnic groups (Allen et al., 1997 **[Level III]**). This instrument is highly effective for use with elders as well.

    - Fagerstrom Test for Nicotine Dependence (Pomerleau et al., 1994 **[Level V]**).

This six-question scale provides an indicator of the severity of nicotine dependence (Scores of 0-2, Very low, to 8-10, Very High). The questions inquire as to first use early in the day, amount and frequency, inability to refrain, and smoking despite illness. This instrument has good internal consistency and reliability in culturally diverse, mixed-gender samples.

- Atypical Presentation:

  Men and women older than 65 may have substance-use and dependence problems even though the signs and symptoms may not correspond to those listed in the *Diagnostic and Statistical manual, Fourth Edition* (*DSM-IV TR)*.

- Signs of central nervous system (CNS) Intoxication (i.e., slurred speech, drowsiness, unsteady gait, decreased reaction time, impaired judgment, disinhibition, ataxia):
  - Assess in individual or collateral (speaking with family members) data collection, consumption of amount and type of depressant medications including alcohol, sedatives, hypnotics, and opioid or synthetic opioid analgesics.
  - Assess vital signs and determine respiratory, cardiac, or neurological depression.
  - Assess for treatable existing medical conditions, including depression.
  - Arrange for emergency room/hospitalization treatment as necessary.
  - Obtain urine for toxicology, if possible.
- At-risk Drinking Consumption of alcohol in excess of one drink per day for seven days a week or more than three drinks on any one occasion (U.S. Department of Health and Human Services [USDHHS], 2005 **[Level VI]**).
  - Assess for readiness to change behavior using Stages of Change Model (Prochaska, & Di Clemente, 1992 **[Level II]**).
  - Is drinker concerned about amount or consequences of the drinking? Has she/he contemplated cutting down?
  - Does she/he have a plan for cutting down/stopping consumption?
  - Has he/she previously stopped but then resumed risky drinking?
  - Personalized feedback and education and education on at-risk drinking results in a reduction in at-risk drinking among older primary-care patients (Fink et al., 2005 **[Level III]**).
- Signs of Withdrawal of CNS Depressant Drugs Including Alcohol (such as tremors, disorientation, tachycardia, irritability, anxiety, insomnia, moderate diaphoresis):
  - May develop extreme CNS stimulation and progress to seizures, hallucinosis, withdrawal delirium, extreme hypertension, profuse diarrhea, from 4 to 8 hours and for up to 72 hours following cessation of alcohol intake (Delirium Tremens/DTs).
  - Assess for risk factors: (a) previous episodes of detoxification, (b) recent heavy drinking, (c) medical comorbidities including liver disease, pneumonia, anemia, (d) previous history of seizures or delirium (Wetterling et al., 2006 **[Level III]**).
  - Assess neurological signs using the *CIWA-AR.* This Clinical Institute Withdrawal Assessment of Alcohol Scale, revised (CIWA-AR), is a 10-item rating scale that delineates symptoms of gastric distress,

perceptual distortions, cognitive impairment, anxiety, agitation, and headache (Sullivan et al., 1989 **[Level III]**).
        - Medicate with a short-acting benzodiazepine (lorazepam or oxazepam) in doses titrated to patient's score on the CIWA, patient's age and weight (Sullivan et al., 1989 **[Level III]**).
- Reported Sleep Disturbance, Anxiety, Depression, Problems with Attention and Concentration (Acute Care):
    - Assess for neuropsychiatric conditions using the Mental Status exam, Geriatric Depression Scale, or Hamilton Anxiety Scale. (See the National Guideline Clearinghouse [NGC] summaries of the Hartford Institute for Geriatric Nursing protocols Dementia and Depression).
    - Obtain sleep history because drugs disrupt already altered sleep patterns in older persons.
    - Assess intake of all drugs, including alcohol, OTC, prescription, herbal and food supplements, and nicotine. Use Brown Bag strategy.
    - If positive for alcohol use, assess for last time of use and amount used.
    - Assess for alcohol or sedative drug withdrawal as indicated.
- Smoking Cigarettes or Using Smokeless Tobacco:
    - Assess for level of dependence using the Fagerstrom Test (See tool above).

Nursing Care Strategies

- At-risk Drinking (consumption of alcohol in excess of one drink per day for seven days a week or more than three drinks on any one occasion):
    - Hydrate with clear fluid by mouth (p.o.) as indicated. Limit use of intravenous fluid except as necessary. Hospitalize if:
        - Blood alcohol level (BAL) >100 mg/dL
        - Severe withdrawal symptoms
        - Suicidal ideation or attempts
        - Comorbid conditions that compromise treatment
        - Polysubstance dependence
    - Conduct Brief Intervention (FRAMES) (Dyehouse, Howe, & Ball, 1996 **[Level VI]**).
        - **F**eedback information to patients about current health problems or potential problems associated with their level of consumption.
        - **R**esponsible choice about how to respond to the information provided to the patients is their choice.
        - **A**dvice must be clear about drinking their amounts and recommended moderate levels of drinking.
        - **M**enu of choices is provided by the nurse to the patient/client regarding future drinking behaviors.
        - **E**mpathy is essential to the exchange. Offer information based on scientific evidence, acknowledge the difficulty of change, avoid confrontation.
        - **S**elf-efficacy of the individual is supported and the nurse helps patient explore options for change.
- Smoking cigarettes or using smokeless tobacco.
    - Apply the Five A's Intervention ("Treating tobacco," 2008)
        - Ask: Identify and document tobacco use.

- Advise: Urge the user to quit in a strong personalized manner.
- Assess: Is the tobacco user willing to make a quit attempt at this time?
- Assist: If user is willing to attempt, refer for individual or group counseling and pharmacotherapy.
- Arrange: Referrals to providers, agencies, and self-help groups. Monitor pharmacotherapy once quit date is established. U.S. Food and Drug Administration (FDA)-approved pharmacotherapies for smoking cessation are:
    - Bupropion SR (Zyban) and nicotine replacement products such as nicotine gum, nicotine inhalers, nicotine nasal spray, and nicotine patch. Psychoeducation about these medications is essential.
    - Zyban, for example, should not be combined with alcohol. Nurses working with in-patients in a case-management model were found to produce outcomes in smoking cessation (Smith et al., 2002; Daniel et al., 2004 **[Level II]**).
    - Communicate Caring and Concern:
        - Encourage moderate intensity exercise as a means of reducing cravings for nicotine because 5 minutes of such exercises is associated with short-term reduction in the desire to smoke and tobacco withdrawal symptoms (Daniel et al., 2004 **[Level II]**).
        - Arrange: Schedule follow-up contact in person or by telephone within 1 week after planned quit date. Continue telephone counseling for those using nicotine patches (Cooper et al, 2004; Boyle et al., 2005 **[Level III]**).
- Smoking Marijuana: Little research regarding effective intervention for psychological dependence on marijuana is available. Some guidance can be found in smoking cessation and self-help approaches.
    - Refer to Steps for Smoking Cessation.
    - Refer patient to addiction specialist for counseling for psychological dependence and/or cognitive-behavioral therapy.
    - Refer to community-based self-help groups such as Narcotics Anonymous, Alcoholics Anonymous, and Al-Anon.
    - Encourage development or expansion of patient's social support system.
- Heroin or Opioid Dependence
    - Older long-term opioid users may relapse and require treatment. Methadone or Buprenorphine are current pharmacological treatment options, effective in conjunction with self-help programs and/or psychosocial interventions. (National Institute for Drug Abuse, 2008 **[Level IV]**).
    - Treatment with methadone, a synthetic narcotic agonist, suppresses withdrawal symptoms and drug cravings associated with opioid dependence but requires daily dosing of 60 mg, minimum. It is dispensed only in specially licensed clinics.
    - Buprenorphine (Subutex or Suboxone), recently approved for use in office practice by trained physicians, is an opioid partial agonist-antagonist. Alone and in combination with Naloxone (Suboxone), it can

prevent withdrawal when someone ceases use of an opioid drug and can be used for long-term treatment. Naloxone is an opioid antagonist used to reverse depressant symptoms in opiate overdose and at different dosages to treat dependence.
    - Close collaboration with the prescriber is required because these drugs should not be abruptly terminated, used with antidepressants, and interact negatively with many prescription medications.
- Naltrexone, a long-acting opioid antagonist, blocks opioid effects and is most effective with those who are no longer opioid-dependent but are at high risk for relapse (Srisurapanont & Jarusuraisin, 2005 **[Level III]**).
- Treatment of an older patient who has become addicted to oxycontin or other opioids should be done in consultation with an addictions specialist nurse or physician.
    - It is recommended that the prescriber avoid opioids and the synthetic opioids Demerol, Dilaudid, and Oxycontin. The opioids have high potential for addiction and Demerol has been associated with delirium in elders (Collins & Kleber, 2004 **[Level VI]**).
    - Barbiturates should be avoided for use as hypnotics and the use of benzodiazepines for anxiety should be limited to 4 months (USDHHS, 2004 **[Level IV]**).
- Relapse Prevention
    - Monitor pharmacologic treatment such as Naltrexone as short-term treatment for alcohol dependence. The benefits of this treatment are dependent on adherence, and psychosocial treatment should accompany its use (World Health Organization [WHO], 2000 **[Level I]**). Methadone or Buprenorphine should be used for long-term treatment of opioid dependence.
    - Refer to community-based Alcoholics Anonymous, Narcotics Anonymous, Al-Anon groups, and encourage attendance.
    - Educate family and patient regarding signs of risky use or relapse to heavy drinking or alcohol-dependent behavior.
    - Counsel patient to reduce drug use (Harm Reduction) and engage in relationship healing/building, community or intellectually rewarding activities, spiritual growth, which increase valued nondrinking rewards.
    - Counsel in the development of coping skills:
        - Anticipate and avoid temptation.
        - Learn cognitive strategies to avoid negative moods.
        - Make lifestyle changes to reduce stress, improve the quality of life, and increase pleasure.
        - Learn cognitive and behavioral activities to cope with cravings and urges to use.
        - Encourage development or expansion of patient's social support system.

Follow-Up Monitoring of Condition

- Evaluate for increase in substance use/misuse associated with growing numbers of aging adults.
- Increase outreach to targeted vulnerable populations.

- Document chronic care needs of elders diagnosed with substance-related disorders.
- Monitor alcohol use among older adults with chronic pain (Brennan, Schutte, & Moos, 2005 **[Level III]**).
- Communicate findings to all members of the involved caregiver team.

Definitions:

Levels of Evidence

Level I: Systematic reviews (integrative/meta-analyses/clinical practice guidelines based on systematic reviews)

Level II: Single experimental study (randomized controlled trials [RCTs])

Level III: Quasi-experimental studies

Level IV: Non-experimental studies

Level V: Care report/program evaluation/narrative literature reviews

Level VI: Opinions of respected authorities/Consensus panels

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for selected recommendations.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Patient:

- Improved physical health and function
- Improved quality of life, sense of well-being and mental health

- More satisfying interpersonal relationships
- Enhanced productivity and mental alertness
- Decreased likelihood of falls and other accidents

Nurse

- Increased accuracy in detecting patient problems related to use/misuse of substances
- Interventions will be more evidence-based resulting in better outcomes

Institution

- Increased number of referrals to ambulatory substance-abuse/mental-health treatment programs
- Improved links with community-based organizations engaged in prevention, education, and treatment of elders with substance-related disorders

POTENTIAL HARMS

- Bupropion (Zyban) should not be combined with alcohol.
- Buprenorphine and naloxone use require close collaboration with the prescriber because these drugs should not be abruptly terminated or used with antidepressants, and because they interact negatively with many prescription medications.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

Little research regarding effective intervention for psychological dependence on marijuana is available. Some guidance can be found in smoking cessation and self-help approaches.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Resources
Staff Training/Competency Material

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Naegle M. Substance misuse and alcohol use disorders. In: Capezuti E, Zwicker D, Mezey M, Fulmer T, editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company; 2008. p. 649-76. [71 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2008

GUIDELINE DEVELOPER(S)

Hartford Institute for Geriatric Nursing - Academic Institution

SOURCE(S) OF FUNDING

Hartford Institute for Geriatric Nursing

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Primary Author: Madeline Naegle

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the Hartford Institute for Geriatric Nursing Web site.

Copies of the book *Geriatric Nursing Protocols for Best Practice*, 3rd edition: Available from Springer Publishing Company, 536 Broadway, New York, NY 10012; Phone: (212) 431-4370; Fax: (212) 941-7842; Web: www.springerpub.com.

AVAILABILITY OF COMPANION DOCUMENTS

The followings are available:

- Alcohol use screening and assessment for older adults. Try this: best practices in nursing care to older adults. 2007. Electronic copies: Available from the Hartford Institute for Geriatric Nursing Web site.
- Substance abuse: post-test and evaluation. Continuing education activity. Available from the Hartford Institute for Geriatric Nursing Web site.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on June 11, 2008. The information was verified by the guideline developer on August 4, 2008.

COPYRIGHT STATEMENT

DISCLAIMER

NGC DISCLAIMER

The National Guideline Clearinghouse™ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public

or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at http://www.guideline.gov/about/inclusion.aspx .

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.

Date Modified: 9/15/2008